MACKEY & Associates

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REQUEST FOR HIPAA CERTIFICATION OF CREDITABLE COVERAGE – NON QUALIFYING EVENT

From: _____ Date: _____ Your Initials: _____
Company Name

EMPLOYEE INFORMATION:

1. Name _____ 2. Social Security # _____
Last First MI

3. Address _____ 4. Phone: ( ) _____
City State Zip+4

5. Date of Birth _____ 6. Gender: ☐ ***Male*** ☐ ***Female*** 7. Date of Hire: _____

8. Is the employee terminating his/her coverage? ☐***YES*** ☐***NO***

DEPENDENT INFORMATION FOR THOSE TERMINATING COVERAGE:

9. Spouse Name _____ 10. SSN _____ ☐M / F☐
Last First MI

9a. Child Name _____ 10. SSN _____ ☐M / F☐
Last First MI

9b. Child Name _____ 10. SSN _____ ☐M / F☐
Last First MI

9c. Child Name _____ 10. SSN _____ ☐M / F☐
Last First MI

11. Dependent Address Phone ( ) _____
(if different) Street (include Apt. #) City State Zip+4

12. Dependent's DOB Spouse: _____ Child: _____ Child: _____ Child: _____ Child: _____

14. Date of Coverage Termination _____

15. Reason For Coverage Termination:

Special Enrollment

- ☐ Marriage
- ☐ Adoption / Placement for Adoption
- ☐ Spouse Gains Benefits Thru His/Her Employer
- ☐ Birth of A Child

Annual Open Enrollment (Renewal Date:_____)

16. Indicate The Plan Name of All Coverage The Employee and/or Dependent Is Terminating:

Medical Plan Option: _____
Dental Plan Option: _____
Vision Plan Option: _____
Other Plan Option:

Questions or Comments: _____